City of Scottsdale
Summary Plan Description

City of Scottsdale
PPO Dental Plan through
Delta Dental of Arizona

Effective July 1, 2005

Delta Dental of Arizona PPO Dental Plan
SUMMARY PLAN DESCRIPTION
July 1, 2005

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Delta Dental of Arizona PPO Dental Plan

SCHEDULE OF DENTAL BENEFITS

Annual Deductibles*:	**Annual Benefit Maximum*:**
$ 50 Individual	$1,500 Individual
$150 Family (aggregate)	**Orthodontic Lifetime Maximum:**
	$1,500 Each Dependent Child

The following chart summarizes co-payment amounts paid by the Plan:

Benefit Description	Subject to Deductible	Delta PPO Dentist	Delta Non-PPO Dentist	Explanation
Preventive Services	Yes	100%	90%	Subject to the annual benefit maximum
Basic Services	Yes	80%	70%	Subject to the annual benefit maximum
Major Services	Yes	60%	50%	Subject to the annual benefit maximum
Orthodontic Services and Appliances	Yes	50%	50%	Subject to the lifetime maximum
Prescription Drugs	Yes	80%	80%	Subject to limitations and the annual benefit maximum

*You are responsible for payment of any amount in excess of the Plan payment.

INTRODUCTION

The City of Scottsdale has prepared this booklet to help you understand your benefits. Please read it carefully. Your benefits are affected by certain limitations and conditions, which require you to be a wise consumer of health benefits and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your dentist may recommend them.

This booklet is written in simple, easy-to-understand language.

As used in this booklet, the word plan year refers to the benefit year, which is the 12-month period beginning July 1 and ending June 30. Annual deductibles and benefit maximums will accumulate based on the plan year. The word lifetime as used in this booklet refers to the period of time a covered person is a participant in this Plan or any other plan sponsored by the City of Scottsdale.

Benefits described in this booklet are effective July 1, 2005.

ELIGIBILITY AND PARTICIPATION

Who Is Eligible

You are eligible to participate in this Plan if you are a regular, full-time, job share, or part-time employee with leave benefits, or a City Council member. Part-time with leave employees must be regularly scheduled to work at least 20 hours per week in a benefit designated position on the city's payroll system.

Your eligible dependents may also participate. Eligible dependents include:

Spouse: A spouse must be legally married to the employee.

Dependent Children: Dependent children include natural children, stepchildren, adopted children and children for whom you are legal guardian. A dependent child must rely on you for primary support and maintenance.

Currently, unmarried dependent children until the age of 19, or until age 25 if enrolled in at lease six college credits.

Effective January 1, 2006, dependents who have reached their 19th birthday but have not reached their 25th birthday, must be enrolled for some part of the five months of the tax year for the number of hours or courses required to be considered full-time attendance as defined by the qualified educational organization. A qualified education organization is defined as an educational organization, which normally maintains a regular faculty and curriculum and normally has a body of students at the place where its educational activities are carried on. Qualified educational institutions include colleges, universities, normal schools, technical schools, mechanical schools and similar institutions. Qualified educational institutions do not include non-educational institutions, on-the-job training, correspondence schools, nights and similar institutions.

Domestic Partner: An employee may enroll his or her domestic partner and eligible dependent children of domestic partner in accordance with the rules established by the City of Scottsdale.

You may not participate in this Plan as an employee and as a dependent. In addition, a person

may not participate in this Plan as a dependent of more than one employee.

Who Pays For Your Benefits

This program is self funded and paid for by contributions from the City of Scottsdale and employees participating in the Plan. To maintain reasonable rates we ask participants to use Plan benefits wisely.

Enrollment Requirements

You must enroll within 31 days of your eligibility date. If you also desire dependent coverage, you must enroll your eligible dependents at this time. If you do not have any eligible dependents at the time of initial enrollment but acquire eligible dependent(s) at a later date, you must enroll the dependent(s) within 31 days of the date.

If you or your dependents are not enrolled within 31 days of the date you become eligible, you may apply for coverage at the next Open Enrollment Period. Coverage will be effective at the beginning of the next plan year July 1.

When Coverage Begins

When the enrollment requirements are met, your coverage begins on the first day of eligibility. However, your coverage does not begin unless you are actively at work. Coverage for your dependents is effective the first day the dependent is eligible.

When Coverage Ends

Your coverage ends the earliest of the date your employment with the city ends, the date contributions cease or the date you are no longer eligible to participate in this Plan.

Coverage for your dependents ends the earliest of the date yours does, the date a dependent no longer meets the eligibility requirements or the date contributions cease.

The City of Scottsdale and the Plan Administrator intends the Plan to be permanent, but since future conditions affecting your employer cannot be anticipated or foreseen, the City of Scottsdale reserves the right to amend, modify or terminate the Plan at any time, which may result in the termination or modification of your coverage. Expenses incurred prior to the Plan termination will be paid as provided under the terms of the Plan prior to its termination.

Changes in Benefit Elections

Generally, your Plan elections must stay in effect for the entire Plan Year. There are certain limited circumstances under which you are permitted to revoke or change your annual election. The following events are changes that if consistent with the requested change in your benefit election will permit you to change your election during a Plan Year.

- You get married or divorced
- You have a child or adopt a child
- Your spouse or child dies
- Your spouse commences or terminates employment
- Your (or your spouse's employment status changes from full-time to part-time or from part-time to full-time)
- You (or your spouse) take an unpaid leave of absence
- There is a significant change in the dental coverage that is provided by your spouse's employer
- At your or your spouse's open enrollment period

Special Situations, Extension of Coverage

Coverage continued under this provision is concurrent with coverage continued under Optional

Continuation of Coverage (COBRA).

A dependent child over age 19 who is continuously incapable of self-sustaining employment because of a mental or physical handicap, is chief dependent upon the employee for support and has become incapacitated before the limiting age maybe eligible for coverage The Plan may require you at any time to obtain a physician's statement certifying the physical or mental handicap.

If you are on an approved unpaid medical or personal leave of absence, eligibility may continue for a maximum of 12 months following the date the leave began. If coverage terminates while you are on an approved leave of absence, coverage will be reinstated on the first day you return to active service provided you meet all the eligibility requirements and return within 6 months after the termination of coverage and immediately after the leave of absence ceases.

DENTAL BENEFITS

About Your Dental Benefits

All benefits under this Plan must satisfy some basic conditions. The following conditions are commonly included in dental benefit plans but are often overlooked or misunderstood.

Alternate Procedure

When more than one dental service could provide suitable treatment based on common dental standards, the Plan will authorize treatment only for the most cost effective treatment of a dental condition. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. You and your dentist are free to apply this benefit payment to the treatment of your choice; however, you are responsible for the expenses incurred which exceed Covered Expenses. For this reason it is recommended to utilize a predetermination of benefits when major dental services are needed, so that you and your dentist know in advance what the benefit plan will cover before any treatment begins.

"DeltaPremier" Participating Dentist Network

The City of Scottsdale has contracted with Delta Dental of Arizona to use their "DeltaPremier" Participating Dentist Network. Delta Dental has negotiated contracts with a network of general dentists and specialists nationwide. This provides you the opportunity to obtain services from participating dentists who agree to accept Delta Dental's Maximum Plan Allowance.

This program utilizes the network developed by Delta Dental to provide dental care while helping to reduce the costs of that care. A greater portion of your dental expenses will be covered when you receive services from a participating dentist. To find a "DeltaPremier" participating dentist or specialist go to www.deltadentalaz.com.

Maximum Plan Allowance

The Plan provides benefits for covered expenses that are equal to or less than the maximum plan allowance as determined by Delta Dental of Arizona. Delta Dental of Arizona utilizes the filed fees of all participating dentists in Arizona to establish the maximum plan allowance. Any amount exceeding the maximum plan allowance is not recognized by the Plan for any purpose.

Dental Care Providers

The Plan provides benefits only for covered services tendered by a dentist or dental hygienist, as those terms are specifically defined in the Definitions section.

Benefit Year

The word benefit year as used in this document, refers to the benefit year, which is the 12-month period beginning July 1 and ending June 30th. All annual benefit maximums and deductibles accumulate during the benefit year.

Deductibles

A deductible is the amount of covered expenses you must pay during each benefit year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. One family member must satisfy 100% of the individual $50 deductible before the family deductible may be considered satisfied. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that benefit year. The annual individual and family deductible amounts are shown on the Schedule of Dental Benefits.

Co-insurance

Co-insurance represents the portions of covered expenses paid by you and by the Plan after satisfaction of any applicable deductible. These percentages apply only to covered expenses, which do not exceed Delta Dental's maximum plan allowance. You are responsible for all non-covered expenses and any amount, which exceeds the maximum plan allowance for covered expenses. The co-insurance percentages are shown on the Schedule of Dental Benefits.

Benefit Maximums

Total Plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum for each specific benefit category may apply on an annual or time basis. Whenever the word lifetime appears in this Plan in reference to benefit maximums, it refers to the time you or your dependents are covered by this Plan or any other plan sponsored by the City of Scottsdale.

The benefit maximums applicable to this Plan are shown on the Schedule of Dental Benefits.

Covered Preventative Services

The Plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered preventative services according to all provisions, requirements and limitations of the Plan.

- Exams, evaluation or consultations, limited to twice a year.
- Prophylaxis (routine cleaning of the teeth), limited to twice a benefit year, or one difficult cleaning may be exchanged for one routine cleaning. However, the difficult cleaning is limited to not more than once in a five-year period.
- Examination in connection with emergency palliative treatment.
- Bite-wing x-rays, limited to twice a year.
- Full mouth x-ray series/panoramic film, vertical bitewings is a benefit, limited to once in a period of 24 months from the date this procedure was last performed.
- Topical application of sodium or stannous fluoride, limited to twice per year.
- Sealants for children up to age 19. Sealants are a benefit once in a three (3) years interval from the date last performed. Sealants are a benefit for the occulsal surface (free from caries or restorations) on permanent bicuspids, first and second molars.

Covered Basic Services

The Plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered basic services according to all provisions, requirements and limitations of the Plan.

- Space maintainers for missing posterior (baby) primary teeth for children up to age 19.
- Injections of antibiotic drugs by the attending dentist.
- Tooth extractions.
- Administration of general anesthesia and/or intravenous sedation in connection with oral surgery.
- Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed teeth.
- Oral surgery, including surgical extractions.
- Study models.

Covered Major Services

The Plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered major services according to all provisions, requirements and limitations of the Plan.

- Gold foil restorations.
- Treatment of periodontal and other gum diseases and supporting structures of the mouth.
- Endodontic treatment.
- Installation of crowns, bridges, or partials.
- Initial installation of dentures.
- Inlays, onlays and crowns. Porcelain allowance for front teeth only, excluding molars.
- Repair or re-cementing of crowns, inlays or onlays.
- Necessary repair or replacement of crowns or gold fillings due to tooth decay.
- Adjusting, relining or re-basing of dentures.
- Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth, which were extracted while covered under this Plan. Installation must be completed within 12 months of the extractions.
- Replacement of an existing partial or full removable denture or fixed bridgework; the addition of teeth to an existing partial or removable denture; or, bridgework to replace teeth which were extracted and satisfactory evidence is presented to the Plan that such change is required due to one of the following:
    - The addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed and while a participant in the Plan and the addition of teeth is completed within 12 months of the extraction.
    - The existing denture or bridgework cannot be made serviceable and was installed at least 5 years prior to the replacement date.
    - The existing denture is an immediate temporary denture replacing one or more natural

teeth extracted while participating in the Plan, replacement by a permanent denture is required, and the replacement takes place within 12 months from the placement of the temporary denture.

- The replacement of existing denture or fixed bridgework is due to an accidental injury requiring oral surgery, which occurred while covered under this Plan and the replacement is completed within 6 months of the accident.

- Periodontal appliances. Occlusal adjustment, only in connection with periosurgery.
- Implants are only a benefit to replace a single missing tooth. Limited to $1,000.00 per tooth, per lifetime and is applied to the patient's benefit year maximum.

Covered Orthodontic Services

Includes coverage for orthodontic appliances and treatments when they are provided to correct problems of growth and development (which may be the cause of malocclusion, periodontal disease, temporomandibular dysfunction, or combinations of these problems).

Benefits will not be provided for the replacement or repair of any appliance used during orthodontic treatment.

Benefits are only available for dependent children banded prior to age seventeen (17) and benefits for active orthodontic treatment are limited to 24 consecutive months of treatment and benefits for retention treatment are limited to 12 consecutive months. Benefits are limited to one treatment per lifetime. In order to be eligible for coverage, an active appliance must not have been installed prior to the eligibility date.

Diagnostic benefits, including examinations, study models, x-rays, and all other diagnostic aids, will be provided only once.

Orthodontic services are paid at 50% co-insurance with a lifetime maximum of $1,500 per individual. Benefit is payable in two (2) payments, upon initial banding and twelve months after. After orthodontic treatment has been completed, no further benefits will be paid.

Prescription Drugs

The Plan will provide prescription benefits prescribed by a covered dental provider. Coverage is excess of any prescription benefit and co-payments the participant is eligible to receive from any group health insurance and subject to all provision, requirements and limitations of the Plan.

Dental Expense Limitations, Procedures and Appliances Not Covered

The Plan will not provide benefits for any of the items listed in this section. This list is intended to give you a general description of expenses for services and supplies not covered by the Plan. There may be expenses in addition to those listed below which are not covered by the Plan.

- Services rendered by anyone other than a covered licensed dental care provider.
- Any portion of a charge, which exceeds the maximum plan allowance for the geographic area in which services are rendered.
- Any service, supply or treatment, which does not meet the standards accepted by the American Dental Association (ADA).
- Services or supplies for which there is no legal obligation to pay, or charges, which would not be made except for the availability of benefits under the Plan.
- Services furnished by or for the U.S. government or any other government, unless payment is legally required.

- Any condition, disability or expense sustained as a result of being engaged in: an illegal occupation; commission of or attempted commission of an assault or other illegal act; intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime; participation in a civil revolution or a riot; duty as a member of the armed forces of any state or country; or act of war which is declared or undeclared.
- Any condition or disability sustained as a result of being engaged in any activity primarily for wage, profit or gain, or that could entitle the covered, person to, a benefit under the Workers' Compensation Act or similar legislation.
- Services or supplies, which are primarily cosmetic or experimental in nature.
- Expenses for preparing dental reports (except when requested by the Plan), itemized bills or claim forms.
- Mailing and/or shipping and handling charges.
- Charges for missed appointments or telephone calls.
- Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.
- Expenses used to satisfy Plan deductibles.
- Travel expenses of a dentist or a covered person.
- Intentional self-inflicted injury or illness while sane or insane.
- Expenses eligible for consideration under Covered Medical Expenses of a health and/or dental insurance program.
- Expenses incurred for services rendered prior to the date of coverage under this Plan.
- Training, educational instruction or materials relating to dietary counseling, personal oral hygiene or dental plaque control.
- Charges for general anesthesia, except when administered by a dentist in connection with oral surgery in the dentist's office.
- Charge for any duplicative prosthetic device (such as bridges or dentures) or other duplicate dental appliance, or charge for the replacement of any lost, missing or stolen prosthetic device or other dental appliance.
- Services and supplies for personalization or characterization of prosthetic devices.
- Charges for services and supplies related to diagnosis or treatment of the temporomandibular joint (T.M.J.) Syndrome.
- Charges for Gnathologic recordings of jaw movements and positions.
- Complete occlusal adjustments and charges for appliances or restorations to increase the vertical dimension or to restore the occlusion.
- Charges for precision attachments except when to restore damage from an accident occurring while a member of the Plan and when they represent the sole method of completing a course of treatment.
- Myofunctional therapy.

- Athletic mouth and Night guards.
- Veneers.
- Hospital charges.
- Charges for complications arising out of treatment or service not covered (excluded) under this Plan.
- Anterior space maintainers are not a covered benefit.

COORDINATION OF BENEFITS

General Provisions

When you and/or your dependents are covered under more than one group health and/or dental plan, the combined benefits payable by this Plan and all other group plans will not exceed 100% of the eligible expense incurred by the individual. The Plan assuming primary payor status will determine benefits first without regard to benefits provided under any other group health or dental plan.

When this Plan is the secondary payor, it will reimburse, subject to all Plan provisions, the balance of remaining eligible expenses, not to exceed normal Plan liability.

For purposes of coordination, eligible expense means any usual and customary charge considered in part or full by at least one of the plans.

Federal Programs

The term group health and/or dental plan includes the Federal programs Medicare, Medicaid and CHAMPUS/TRICARE. The regulations governing these programs take precedence over the order of determination of this Plan.

Other Group Plans

Any group health or dental plan, which does not contain a coordination of benefits provision, will be considered primary.

When all plans covering you and/or your dependents contain a coordination of benefits provision, order of payment will be as follows:

- If a person is covered under a plan as an active employee, that plan will be primary over a plan covering the same person as a retiree.
- When a person is an active employee under more than one plan, the Plan covering the individual for the longer period of time will be considered primary.
- The Plan covering a person as an employee or a dependent will be primary over the plan providing continuation coverage (COBRA),
- A plan covering a person as a dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birth date (month and day) in the year. If both parents have the same birth date, the plan covering the child for the longer period of time will be primary.

Children of Divorced or Separated Parents

When all plans covering a person as a dependent child of divorced or separated parents contain a coordination of benefits provision, the order of payment will be:

- The plan covering the dependent child of the natural parent designated by court order to be responsible for the child's health care expenses will be considered primary.

- In the absence of a court order specifying otherwise, the plan covering the dependent child of the natural parent having legal custody of the child will be considered primary.

- In the absence of a court order specifying otherwise, the plan covering the dependent child of a stepparent who is the spouse of the natural parent having legal custody of the child will be considered primary.

Right To Make Payments To Other Organizations

Whenever payments, which should have been made by this Plan, have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this Plan and, to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom payment was made.

OTHER IMPORTANT PLAN PROVISIONS

Assignment Of Benefits

All benefits payable by the Plan may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the Plan's obligation to the extent of the payment.

Acts Of Third Parties

This provision applies if it appears you or your dependent(s) may have suffered illness or injury because of an act or omission of another person. If you recover expenses from a legal judgment, settlement or any other means, you must reimburse the Plan for expenses paid by the Plan relating to the illness or injury.

No benefits will be paid until you complete and sign a statement, provided by the Plan, agreeing to reimburse the Plan if these expenses are recovered.

Recovery Of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these excess payments from any individual, insurance company or other organization to whom the excess payments were made or the right to withhold payment on future benefits until the overpayment is recovered.

Right To Receive And Release Information

The Plan may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement Plan provisions. When you request benefits, you must furnish all the information required to implement Plan provisions.

Alternate Payee Provision

Under normal conditions, benefits are payable to you and can only be paid directly to another party upon signed authorization from you. If conditions exist under which a valid release or

assignment cannot be obtained, the Plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment.

The Plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the Plan.

Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to you.

OPTIONAL CONTINUATION OF COVERAGE

Continuation Of Coverage Under Federal Law

As mandated by Federal law, the Plan offers optional continuation coverage to you and/or your dependents if coverage would otherwise end due to one of the following events:

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and your eligible dependents.
- A reduction in hours worked by you, which results in loss of Plan eligibility. Coverage may continue for you and your eligible dependents.
- Your death. Coverage may continue for your eligible dependents.
- Divorce or legal separation from your spouse. Coverage may continue for that spouse and your eligible dependents.
- You become entitled to Medicare. Coverage may continue for eligible dependents that are not entitled to Medicare.
- Loss of eligibility of a covered dependent child due to Plan eligibility requirements. Coverage may continue for that dependent.

To choose this continuation coverage, an individual must be a covered person under the Plan on the day before the qualifying event.

Notification Requirement

To choose this continuation coverage, an individual must be a covered person under the Plan on the day before the qualifying event.

You or the qualifying individual has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the City of Scottsdale Dental Plan within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of continuation coverage rights.

Children, newly born or placed for adoption during the continuation period, may be added to the covered employee's COBRA coverage as qualified beneficiaries.

You are allowed to change your coverage status (from individual to family) at open enrollment; or upon marriage and/or the birth or adoption of a new child. You must notify the Plan Administrator within 30 days of the event.

You or a member of your family has the responsibility of notifying the Plan Administrator of your death, termination of employment, reduction in hours or entitlement to Medicare within 30 days of the qualifying event.

The Plan will notify you or the qualifying individual of continuation coverage rights within 14 days of the notice described above. You will then have 60 days to elect continuation coverage. Failure to elect continuation coverage within 60 days after the plan administrator notifies you will result in loss of continuation coverage rights.

Maximum Period of Continuation of Coverage

The maximum period of continuation coverage for individuals who qualify due to termination of employment or reduction in hours worked is 18 months from the date of the qualifying event.

An employee, spouse or dependents, may extend existing COBRA coverage from 18 to 29 months, if the Social Security Administration determines the disabled beneficiary(ies) were or became totally disabled at any time during the original 18 months of COBRA continuation coverage. To qualify for this extension, the person must submit a copy of the Social Security disability determination notice within 60 days of the date of such notice to the COBRA administrator.

The maximum period of continuation coverage for individuals who qualify due to any other described qualifying event is 36 months from the date of the qualifying event.

If an individual experiences more than one qualifying event, the maximum period of coverage will be computed from the date of the earliest qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

However, if your spouse and dependent children would otherwise lose coverage because of a qualifying event, they will be entitled to 36 months of continuation coverage from the date you become entitled to Medicare even if your entitlement to Medicare does not cause you to lose coverage either because you are still employed or because you had already terminated employment.

Cost of Continuation Coverage

The cost of continuation coverage is determined by your employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the Plan's cost of coverage.

You or the qualified individual must make the first payment within 45 days of notifying the Plan of selection of continuation coverage. Future payments can be made in monthly installments within 30 days of the due date unless your employer establishes a longer payment schedule. Rates and payment schedules are established by your employer and may change when necessary due to Plan modifications.

The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

- The date the maximum continuation period expires;

- The date the qualifying individual becomes entitled to coverage under Medicare;
- The last period for which payment was made when coverage is cancelled due to nonpayment of the required cost;
- The date the employer no longer offers a group dental plan to any of its employees; or
- The date the qualifying individual becomes covered under another group dental plan. However, COBRA coverage may be continued under provisions of the Federal Health Insurance Portability and Accountability Act of 1996, until the new employer's group dental plan covers the insured's without regard to any preexisting conditions.

DEFINITIONS

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under Covered Dental Expenses.

Accident

An undesirable or unfortunate happening, unintentionally caused and usually resulting in harm, injury, damage or loss.

Actively at Work (Active Employment)

You are considered to be actively performing in the customary manner all of the regular duties of your occupation with the employer, either at one of the employer's regular places of business or at some location to which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or non-working day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled work day.

Age Discrimination

A violation of the Social Security Act, which states that all active employees and their covered dependents age 65 and over are entitled to the same and/or equal benefits they had prior to age 65.

Alternate Procedure

The most cost effective treatment of a dental condition, which will provide a professionally acceptable result as determined by national standards of dental practice. Consideration is given to the current clinical oral condition based upon the diagnostic material submitted by the dentist.

Amendment (Amend)

A formal document signed by the representatives of the City of Scottsdale. The amendment changes the provisions of the Plan and applies to all covered persons, including those persons covered before the amendment becomes effective, unless otherwise specified.

DDAZ:

Delta Dental of Arizona

Dentist

A person acting under the scope of his or her license to provide dental care as:

D.D.S. – Doctor of Dental Surgery

D.M.D. – Doctor of Medical Dentistry

Non-Participating Dentist

On the date of service, if your dentist is a Non-participating Dentist (a dentist who has not signed an agreement with Delta Dental of Arizona, or who has terminated as a Participating Dentist), benefits will be based on the lesser of billed charges or Delta Dental of Arizona's Non-participating Dentist allowable fees. Claim forms are available on DDAZ's web site at www.deltadentalaz.com.

- You will be responsible to submit the claims form or pre-determination of benefits form to DDAZ;
- You will be required to pay the difference between any amount billed by the dentist and DDAZ's "allowable" fee. DDAZ will reimburse you for the benefits payable by your Employer Group's plan.
- DDAZ's Non-participating Dentists Table of Allowance is a percentile of the average participating dentist fees filed with DDAZ.
- The Non-participating Dentist Table of Allowance results, in most instances, in a reduced benefit when compared to the benefit paid for the same service to a Participating Dentist.

Partcipating Dentist

On the date of service if the dentist is a Participating Dentist (a dentist who has signed an agreement with DDAZ):

- The dental office will complete the claim forms and submit to DDAZ for payment, pre-determination or coordination of benefits;
- You are required to pay only your coinsurance/co-payment/patient portion (if any) and/or deductible (if any) for covered benefits;
- Payment to the dentist will be based upon the lesser of the Participating Dentist's submitted or usual and customary fee, or DDAZ's Maximum Plan Allowance for services rendered. The Participating Dentist will not bill you more than the allowable fees;
    - Participating Dentists must submit claims within 12 months of the date of service for all services performed to ensure an accurate account of patient history of treatment and proper billing practices.
    - The dentist agrees to abide by DDAZ's benefit determination and administration policies and agrees to accept payment directly from DDAZ.

Plan

The City of Scottsdale Delta Dental PPO Dental Plan.

Schedule of Dental Benefits

The pages in this booklet that specifies the applicable payment percentages, deductible amounts, annual benefit maximums, effective date and other Plan information.

FILING A CLAIM

How To File A Claim

The appropriate claim forms may be obtained directly from the City of Scottsdale. The following general steps should be followed in order to file a claim.

1. Complete the employee portion of the benefits claim form in full. Answer all questions, even if the answer is "none" or "N/A" (does not apply). Many dentists will file the claim for you. If the dentist is filing the claim for you be sure to notify them to include all information noted below.

2. Attach all necessary documentation of expenses to the benefits claim form.

   Documentation must include:

   - a description of services (ADA procedure codes) or supplies provided, detailing the charge for each supply or service;
   - the diagnosis;
   - the date(s) of service;
   - the patient's name;
   - the provider's name, address, phone number and degree;
   - the federal tax identification number of the provider.

3. Complete a separate benefits form for each person benefits are being requested.

4. If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the benefits claim form sent to this Plan.

5. Mail completed claims for benefits to:

   Delta Dental of Arizona.
   PO Box 43000
   Phoenix, AZ 85080-3000

6. If you have any questions regarding your claim, please call:

   (602) 938-3131 or (800) 352-6132

All claims must be filed with the Plan within a 12-month period from the date of the expense.

How To Appeal a Denial of Reimbursement

If you believe a claim for reimbursement was improperly settled, the following process is available:

1. Request a review of the processed reimbursement claim within 60 days. The Plan will review the processed reimbursement claim and inform you whether or not an error was made. Any errors will be corrected promptly.

2. All requests for a review of a denial of reimbursements should include a copy of the initial denial letter, group fund number, claim number any additional pertinent information and be addressed to:

   Claims Review Committee
   Delta Dental of Arizona.
   PO Box 43000
   Phoenix, AZ 85080-3000

3. If the reimbursement claim is again denied, a subsequent denial letter will be sent and you may request a further review of the denial by the Plan administrator.

4. You must make the request to the Plan administrator in writing within 60 days of the date of receipt of the reviewed denial letter, providing additional information and a copy of the reviewed denial letter to:

   Plan Administrator
   City of Scottsdale, Human Resources Department
   7575 E. Main Street
   Scottsdale, AZ 85251

5. You will be advised of the decision of the Plan administrator in writing within 60 days, or if a decision cannot be reached due to lack of information, you will be requested to submit the additional information in writing, or by personal interview, at the discretion of the Plan administrator.

Requests for appeal, which does not comply with this procedure and time limitations, will not be considered, except in cases of extraordinary circumstances.